

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11234 CERTIFICATE OF DEATH

11227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Chas.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thermerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlotte Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CLARK JAMES BRAGG</u>		DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer in Self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Nelson Bragg</u>		14. MOTHER'S MAIDEN NAME <u>Engelma Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>101-10-10101</u>	
17. INFORMANT <u>Walter C. Cabell</u>		Address <u>Hughesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10-12-58</u> <u>1945</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dr. Bragg's attending physician's office</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-12-58</u> alive on <u>19</u> and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		DATE SIGNED <u>10-12-58</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>		<u>L. A. Plata</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT.</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Weldoy, Md</u>	
24a. REC'D BY REGISTRAR <u>Oct 16 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235 CERTIFICATE OF DEATH

11228

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LAZARUS Peter</u> First Middle Last		4. DATE OF DEATH <u>Oct 28</u> Month Day Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Powder Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Dodd</u>		14. MOTHER'S MAIDEN NAME <u>Emma Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary F. Dodd, Nanjemoy, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>10-28</u> , 1958, that I last saw the deceased alive on <u>10-26</u> , 1958, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. M. JOHNSON</u> M.D.		DATE SIGNED <u>La Plata, Md. 10-28-58</u>	
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON</u>		<u>same</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/1/58</u>	<u>Nanjemo Baptist</u>	<u>Nanjemo, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Uidoff, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>

MASSACHUSETTS DEPARTMENT OF HEALTH - CIVIL DEATH
11287
CERTIFICATE OF DEATH

NEWBURY
BOKALD

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11236 CERTIFICATE OF DEATH

11229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
c. LENGTH OF STAY IN 1b <u>1 hr 25 min</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>La Plata Hospital</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lori</u> First <u>Virginia</u> Middle <u>Intervale</u> Last		4. DATE OF DEATH <u>10-4-58</u> 19 <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-58</u>
9. AGE (In years last birthday) yrs. <u>25</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brooke A. Entwistle</u>		14. MOTHER'S MAIDEN NAME <u>Olive V. Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rev. Herbert Costain, Indian Head, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Citolexis - Pulmonary</u> <u>762.0</u> DUE TO <u>Aschemic General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 20 min</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-4-58</u> , 19 <u>58</u> to <u>10-4-58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>10-4-58</u> , 19 <u>58</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Henderson</u> M.D.		ADDRESS (Street, city or town, state) <u>Indian Head Md</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>10-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Pomonkey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>OCT 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Alton</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) e. STATE <i>Md</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Bel Alton</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROGER</i> First <i>FRANCIS</i> Middle <i>GARNER</i> Last 5. SEX <i>MALE</i> 6. COLOR OR RACE <i>WHITE</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>3-31-13</i> 9. AGE (In yrs. last birthday) <i>45</i> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i> 11. BIRTHPLACE (State or foreign country) <i>Md</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		4. DATE OF DEATH Month <i>OCTOBER</i> Day <i>17</i> Year <i>58</i> 13. FATHER'S NAME <i>Richard W. Garner</i> 14. MOTHER'S MAIDEN NAME <i>Elizabeth Welch</i> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>W.W. 11</i> 17. INFORMANT <i>Bessie Welch</i> Address <i>Bel Alton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>322.1 Chronic Alcoholism</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <i>NONE</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Occurred while walking up a steep hill.</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:30 AM 10-17 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> 20f. (City or town) <i>Bel Alton</i> (County) <i>Charles</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V. B. Dettor</i> EXAMINER'S NAME (Type) <i>V. B. DETTOR</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10-18-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>10/21/1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i> 22d. LOCATION (City, town, or county) <i>La Plata, Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Funeral Home, Inc.</i> 24a. REC'D BY REGISTRAR <i>OCT 22 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11200

11200

CLERK OF THE COUNTY OF ALBANY

ALBANY, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> 11238 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>O.</u> Middle <u>HAGENS</u> Last 		4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Apr 4, 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTH PLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Warren Hagens, Waldorf, Md.</u>		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to smoke</u> <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and 50% second degree thermal burns</u> DUE TO (c) <u>10min</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fire in a closed room</u>	
20c. TIME OF INJURY Hour <u>2:30</u> a.m. <u>10-10-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Waldorf Charles, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>John L. Kline</u>		DATE SIGNED <u>10-10-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22-10-19

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Boston		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
Oct 22, 1919		10:30 AM		Home		Dr. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11239

CERTIFICATE OF DEATH

11232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles, Waldorf</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Waldorf</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Elizabeth</u> Last <u>Hawcock</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1932</u> 26 yrs.	
9. AGE (In years, last birthday) <u>26</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James B. Goldsmith</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Middleton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>George L. Hawcock, Waldorf, Md.</u> Address _____		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized spread of malignant cells</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) <u>Lymphoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1-26</u> <u>1957</u> , to <u>10-10</u> <u>1958</u> , that I last saw the deceased alive on <u>10-10</u> <u>1958</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert N. Doherty</u> M.D. <u>Barney Moore, Md.</u> <u>10-11-58</u>				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>Robert N. Doherty, M.D.</u>				ADDRESS _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>		22d. LOCATION (City, town, or county) <u>Waldorf, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11240

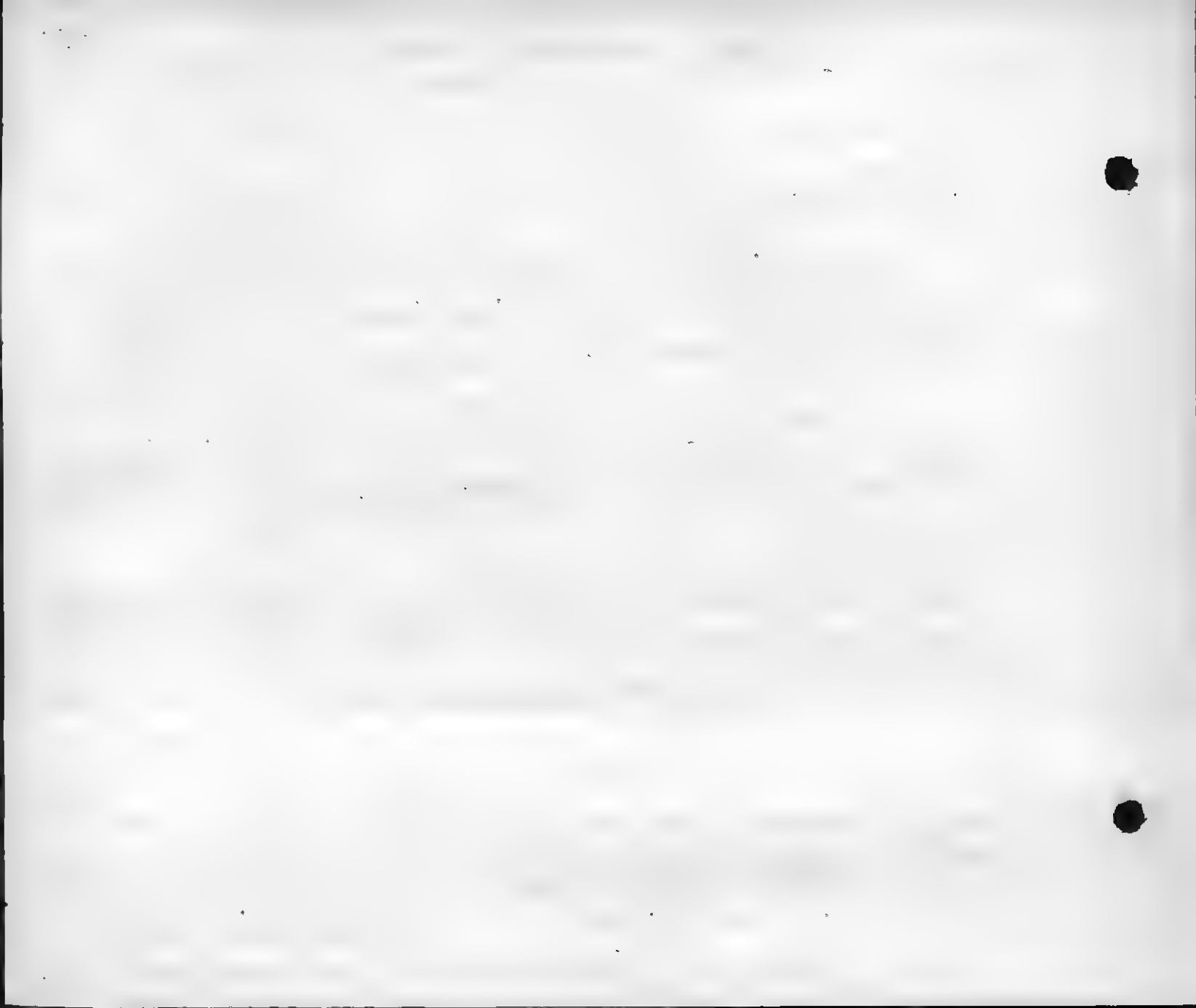
CERTIFICATE OF DEATH

11233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winifred D. Lowe First Middle Last		4. DATE OF DEATH Month Oct Day 30 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1919
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY doctors office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A Dyson		14. MOTHER'S MAIDEN NAME Mirian Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-05-0239	
17. INFORMANT J. Douglas Lowe, White Plains, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POSTOPERATIVE SUBTOTAL GASTRIC RESECTION		INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957 , to Oct 30, 1958 , that I last saw the deceased alive on Oct 30, 1958 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. PARRAN JARBOE M.D.		DATE SIGNED 10-30-58	
PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D.		ADDRESS (Street, city or town, state) La Plata, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Nov. 3 1958	22c. NAME OF CEMETERY OR CREMATORY St. Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR NOV 5 '58	24b. REGISTRAR'S SIGNATURE Chas S. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11234

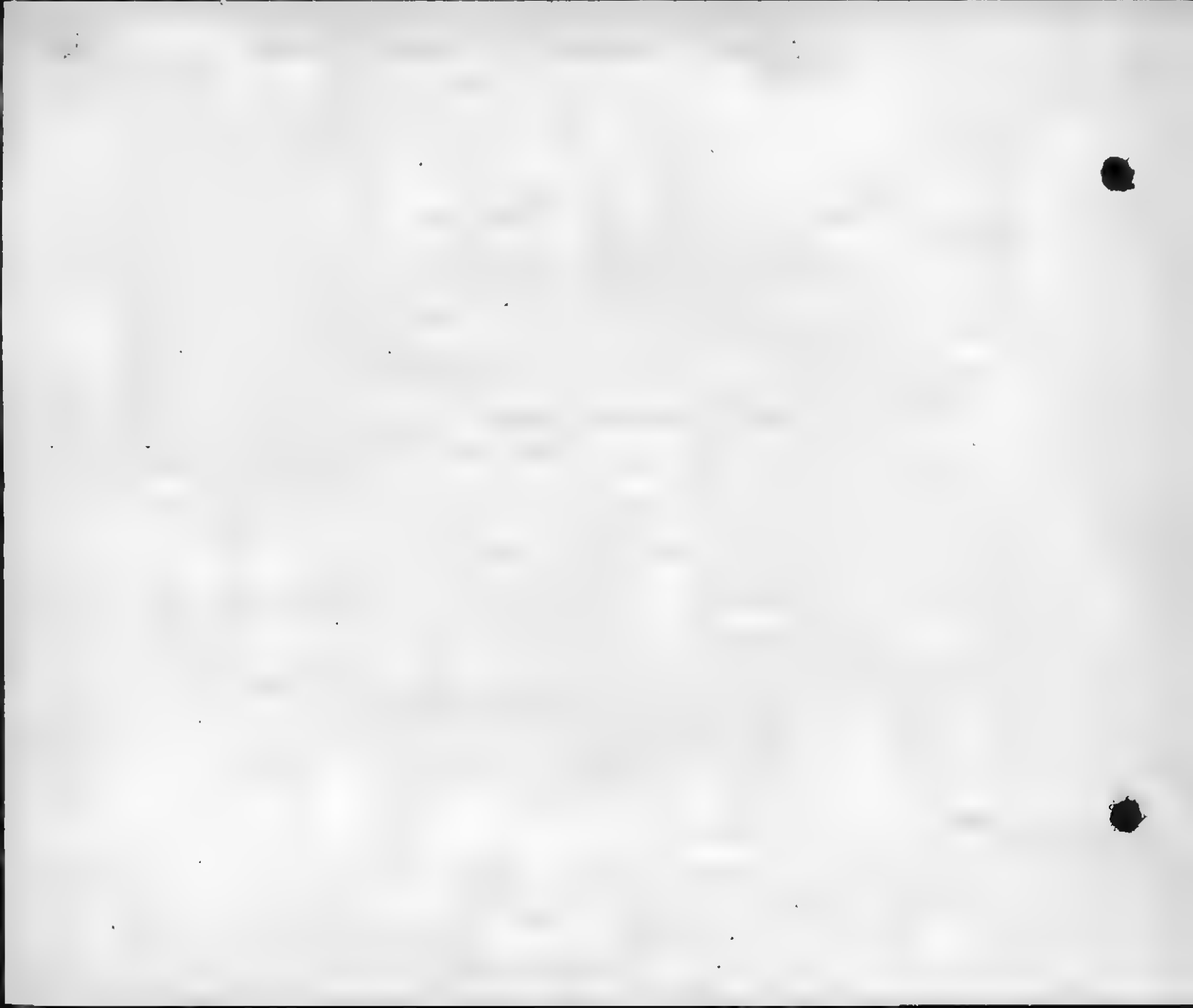
Reg. Dist. No.

11241

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural/Tompkinsville/Charles Co., Md. c. LENGTH OF STAY IN 1b 10/20/1958 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COBB ISLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE BENJAMIN MOORE First Middle Last		4. DATE OF DEATH OCTOBER 17 1958 Month Day Year	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Charles Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard F. Moore	
14. MOTHER'S MAIDEN NAME Elizabeth Roye		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mrs. Carry Thomas (Sister) Tompkinsville, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Accidental Drowning X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable acute alcoholism			INTERVAL BETWEEN ONSET AND DEATH 2 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ship while working	
20c. TIME OF INJURY 4:30 PM 10-17-1958 Hour Month, Day, Year	20d. INJURY OCCURRED While at work While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RIVER	20f. (City or town) Cobb Island, Charles, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V. B. DETTOR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1958	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		22d. LOCATION (City, town, or county) (State) Issue, Charles Co., Md.	
23. FUNERAL HOME'S SIGNATURE Archart Funeral Home, Inc., La Plata, Maryland		24a. REC'D BY REGISTRAR OCT 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SIGNED 10/18/58	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11242

CERTIFICATE OF DEATH

11235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco. - Rural.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STEPHAN</u> Middle <u>NALBORCZYK</u> Last <u>NALBORCZYK</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-03</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGR.</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>POLAND.</u>	
13. FATHER'S NAME <u>Johann Nalborczyk.</u>		14. MOTHER'S MAIDEN NAME <u>KAROLINA KUBIK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-620</u>	
17. INFORMANT <u>Maria Nalborczyk</u>		Address <u>Port Tobacco</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive hemorrhage from upper G.I.</u> DUE TO (c) <u>Gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>36 hrs.</u> <u>6 mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1956</u> , to <u>Oct 23, 1958</u> , that I last saw the deceased alive on <u>23 October, 1958</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above EOT ADDRESS (Street, city or town, state) DATE SIGNED <u>LaPlata, Md.</u> <u>23 Oct 58</u>			
ACTUAL SIGNATURE <u>Arthur O Woodydy</u> M.D.		DATE SIGNED <u>23 Oct 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O WOODYDY</u>		LaPlata, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City town, or county) (State)
<u>Burial</u>	<u>10/25/58</u>	<u>St. Thomas Cemetery Chapel Point, Md.</u>	<u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard Funeral Home, Inc LaPlata, Md.</u>		24a. DIED BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		<u>DATE</u> <u>OCT 29 '58</u>	<u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last NORRIS		4. DATE OF DEATH Month OCTOBER Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1873
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 5 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Norris		14. MOTHER'S MAIDEN NAME Mary V. Farrall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Robert Nalley (Niece)		Address La Plata, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory collapse 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary artery atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old CVA in Sept 1951			INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3 mths
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1951 to 2 Oct 1958 , that I last saw the deceased alive on 2 Oct 1958 , and that death occurred at 11:58 P.M. from the causes and on the date stated above EDT ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 20 Oct 58			
ACTUAL SIGNATURE Arthur Wooddy M.D.		PHYSICIAN'S NAME (Type) ARTHUR WOODDY, M.D.	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF Oct. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Newport, Charles Co., Md.
23. FUNERAL HOME'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MD.		24a. REC'D BY REGISTRAR DATE OCT 7 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last ROBEY		4. DATE OF DEATH Month Oct Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27/58
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME William Mason Robey	
14. MOTHER'S MAIDEN NAME Dolly Betty Robey Boswell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO		17. INFORMANT Mother, La Plata, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Contracted pelvis at birth		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-27, 1958 , to 10-27, 1958 , that I last saw the deceased alive on 10-27, 1958 , and that death occurred at 10:10 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE F. M. Johnson M.D.		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 10-27-58	
PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Oct 28 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Folkland Md
23. FUNERAL DIRECTOR'S SIGNATURE Howard Funeral Home		ADDRESS Waldorf, Md	
24a. REC'D BY REGISTRAR OCT 29 58		24b. REGISTRAR'S SIGNATURE William B. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road, MARSHALL HALL</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		d. STREET ADDRESS <i>Rural</i>	
3. NAME OF DECEASED (Type or print) First <i>Florence</i> Middle <i>A.</i> Last <i>Waterman</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>5</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 1, 1892</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Steven G. Dixon</i>		14. MOTHER'S MAIDEN NAME <i>MARY AGNES ROBINSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>	
17. INFORMANT <i>Miss Margaret Hoover</i>		Address <i>Bryans Rd. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocarditis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>431X</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X</i> <i>Diabetes Mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 2, 1958</i> to <i>Oct 5, 1958</i> , that I last saw the deceased alive on <i>Oct 4, 1958</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Frank G. Pusam M.D.</i> <i>10-6-58</i>			
ACTUAL SIGNATURE <i>Frank G. Pusam</i>		PHYSICIAN'S NAME (Type) <i>Frank A. Susen M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/9/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>NAT'L. MEM. PARK CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>FALLS CHURCH, VIRGINIA</i>	
23. ALTERNATE REGISTRAR <i>Raymond A. Giska</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 8 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

[Faint, mostly illegible handwritten text on a death certificate form. The form includes sections for personal information, cause of death, and medical history.]



BALTIMORE, 18

Items 7, 11, 12 Film 235 10-23-58 et

11246 CERTIFICATE OF DEATH

11240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial Hosp.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Winters Last 10				4. DATE OF DEATH Month 10 Day 13 Year 1958					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-1889		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months 69 Days 13 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Edelen				14. MOTHER'S MAIDEN NAME Louise Taylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 218 38 8450		17. INFORMANT McKinley A. Winters, La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1957 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1957 , 19 , to 10-13 , 1958 , that I lost 10-13 , 1958 , and that death occurred on 11:25 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-17-'58									
ACTUAL SIGNATURE E. J. Edelen M.D.				PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

11-10-1910

Page 100

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